Iowa Department of Personnel

Serving those who serve Iowa

CERTIFIED DISABILITY PROGRAM

TO BE COMPLETED BY IDOP

NAME: _____ SSN: _____

Last, First MI

ADDRESS: _____

_____

JOB CLASSES FOR WHICH QUALIFIED

JOB CLASS	CLASS CODE	JOB CLASS	CLASS CODE

TO BE COMPLETED BY CERTIFYING DEPARTMENT

NATURE OF THE DISABILITY AND REASON FOR WAIVING EXAMINATION:

_____

_____

_____

_____

_____

I certify that the above applicant, in my best judgment, possesses the knowledges, abilities, skills, and personal characteristics necessary to perform the duties of the job class(es) listed. I further certify that, for the reasons expressed above, this applicant cannot compete for the above jobs via participation in the regular examination process without unfair negative impact.

COUNSELOR (print) _____

DEPARTMENT (circle one) DVRS BLIND PHONE _____

_____ _____

Counselor Signature Date

TO BE COMPLETED BY IDOP

The above applicant has ☐ has not ☐ been placed on the appropriate eligible list(s) as a Certified Disability Program applicant.

_____ _____

Signature - IDOP Employment Bureau Date

Copy to Counselor by: _____ Date: _____

Copy to Applicant by: _____ Date: _____

CFN 552-0450